VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

November 18, 2011

Mr. Neil Gruber, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753-8422

Provider #: 475017

Dear Mr. Gruber:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **October 19, 2011.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

PRINTED: 10/25/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475017	A. BUILDING _____ B. WING _____	C 10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	39 PORTER DRIVE MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection initiated an unannounced onsite complaint investigation on 9/28/11, and completed the investigation after offsite review of information on 10/19/11. A regulatory violation was cited as a result.	F 000	Corrective action for this specific resident cannot be achieved since the 48 hours reporting time frame has passed. However, the specific employee involved in this incident has received remedial training relative to the policy. Because all residents have the potential to be affected by the same deficient practice, all employees will receive remedial training regarding the facility's abuse and neglect reporting policy.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of 1 sampled resident (Resident # 1). Findings include: Per interview with the Director of Nursing Services (DNS) on 9/28/11 at 9:03 A.M., a Licensed Nursing Assistant (LNA) did not report suspected resident abuse in a timely manner. Resident # 1 was allegedly verbally and physically abused by an LNA on 6/11/11. An LNA that witnessed the incident did not report the incident to management until 6/21/11. Facility policy states that any suspected abuse must be immediately reported. On 9/28/11 a 9:25 A.M., the Director of Social Services confirmed that the 6/11/11 incident was not reported until 6/21/11.	F 226	The measures that will be put into place to ensure that the deficient practice does not recur include: 1. The web-based training program will be updated to include mandatory reporting along with HPRHC's policy relative to such and will include questions to confirm competency. — 11/14/11 2. Nursing orientation will include a small group training with a member from Social Services to discuss the policy and procedure for reporting abuse. — completed 3. A training program for LNAs specific to resident rights, professionalism, and reporting abuse was conducted in response to this incident — completed in Sept. 4. The policy will be posted on the Nursing Dept. bulletin board for all staff to view. — 11/14/11 Corrective action will be monitored by ensuring that all employees have completed the web-based program successfully within the next three months. Corrective action will be completed by Nov. 14,2012. This plan of correction constitutes our written allegation of compliance for deficiences cited. However, submission of this plan of correction is not an admission that any deficiencies exist or were cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. F226 POC Accepted 11/8/11 R. Tremblay RN/CPM coto RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark H. Moore — TITLE: Administrator — (X6) DATE: 11/7/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.